

12908 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film 6245 6-2-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Henrico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN 1b 1 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNAS			d. STREET ADDRESS 2314 Grove Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard Lewis ATKINSON, Jr.			4. DATE OF DEATH Month November Day 27 Year 1958		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 October 1925		9. AGE (In years last birthday) 33 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pumping Plant Operator		10b. KIND OF BUSINESS OR INDUSTRY Keynolds Metal Co.		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard Lewis ATKINSON, Sr.			14. MOTHER'S MAIDEN NAME Thelma Virginia Phillips Not obtainable		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 11-42/1-46		17. INFORMANT Official U.S. Naval Records (Civil Service) USNAS, Patuxent River, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tension Pneumothorax DUE TO Conditions, if any, which gave rise to immediate cause (b) Multiple Rib Fractures (c), stating the underlying cause last. 816X DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1-1/2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral concussion, and Multiple fractures right femur					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, struck by oncoming vehicle while entering hwy.			
20c. TIME OF INJURY Month, Day, Year 8:45 p.m. 27 Nov. 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md. Sta. Hwy 246	
				20f. (City or town) (County) (State) Lexington Park, St. Mary's, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R. BUFFINGTON, LT MC USNR, USNAS, Patuxent River, Maryland 11-28-58 R. B. Buffington					DATE SIGNED
EXAMINER'S NAME (Type) WM D. BOYD, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>
					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/ 58		22c. NAME OF CEMETERY OR CREMATORY Oakwood	
				22d. LOCATION (City, town, or county) (State) Richmond, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Bliley CO.			ADDRESS Richmond. Va.		
24a. REC'D BY REGISTRAR DEC 2 '58			24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

Section

Date

Place

Time

Weather

Remarks

No.

Name

Age

Sex

Rank

Service

Branch

Regiment

1. Name of vessel

2. Name of commanding officer

3. Name of surgeon

4. Name of assistant surgeon

5. Name of pharmacist

6. Name of steward

7. Name of cook

8. Name of carpenter

9. Name of blacksmith

10. Name of cooper

11. Name of miller

12. Name of baker

13. Name of butcher

14. Name of cooper

15. Name of miller

16. Name of baker

17. Name of butcher

18. Name of cooper

19. Name of miller

20. Name of baker

12909

Reg. Dist. No.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY St. Marys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills		c. LENGTH OF STAY IN 1b X Great Mills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Louis Barber		4. DATE OF DEATH Month 11 / Day 18 / Year 19 58	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1914
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Parren Barber		14. MOTHER'S MAIDEN NAME Mandy Barber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-32-7945	
17. INFORMANT Jos. M. Barber - Great Mills, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 812x Fractured Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 min DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit by auto -	
20c. TIME OF INJURY Hour 7:30 p.m. Month, Day, Year 11-18-1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STATE ROUTE #5	20f. (City or town) (County) (State) Great Mills St Marys Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Wm. D. Boyd MD		DATE SIGNED 11/19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/22/58	22c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery	22d. LOCATION (City, town, or county) (State) Great Mills Md.
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR NOV 24 '58	
		24b. REGISTRAR'S SIGNATURE Arthur E. Huns	

STATE OF TEXAS
COUNTY OF DALLAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6236 12-15-58 et

CERTIFICATE OF DEATH

12910

Reg. Dist. No.

12910

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Thomas Bowles</u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-58</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Leonardtown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>James H. Bowles</u>		14. MOTHER'S MAIDEN NAME <u>Margaret H. Vallandigham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Margaret W. Bowles</u>		Address <u>Leonardtown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 min.</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11/2/58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/31/58</u> , 19 <u>58</u> , to <u>11/2/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/2/58</u> , 19 <u>58</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Gill</u>		ADDRESS (Street, city or town, state) <u>Leonardtown Md</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH E. GILL, M.D.</u>		DATE SIGNED <u>11/2/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		22d. LOCATION (City, town, or county) (State) <u>Leonardtown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Mattingley</u>		ADDRESS <u>Leonardtown, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

15
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Items 8,9,10,13,14/FilmG236 12-3-58 et

12911

12911 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Mechanicsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) <u>Arthur</u> (Middle) (Last) <u>Bush</u>				4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>24</u> (Year) <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 26, 1888</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Bush</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ann (Last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <u>unk.</u>) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>						<u>2-3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>Roy E. [Signature]</u>		M.D. <u>Wesley [Signature]</u>		ADDRESS (Street, city, town, state) <u>Chaptico, Md.</u>		DATE SIGNED <u>11/25/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>11/ 28/58</u>	NAME OF CEMETERY OR CREMATORY <u>John Westley</u>		LOCATION (City, town, or county) (State) <u>Chaptico, Md.</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtwn, Md.</u>		
DATE <u>NOV 26 '58</u>							

1911 CERTIFICATE OF DEATH

Reg. No. _____

1. Name of deceased _____

2. Sex _____

3. Age _____

4. Date of death _____

5. Time of death _____

6. Place of death _____

7. Cause of death _____

8. Nature of disease _____

9. Duration of disease _____

10. Name of physician _____

11. Name of undertaker _____

12. Name of funeral home _____

13. Name of cemetery _____

14. Name of burial place _____

15. Name of interment _____

16. Name of registrar _____

17. Name of registrar _____

18. Name of registrar _____

19. Name of registrar _____

20. Name of registrar _____

21. Name of registrar _____

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89. Name of registrar _____

90. Name of registrar _____

CERTIFICATE OF DEATH

12912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMELIA Middle ---- Last CHAP		4. DATE OF DEATH Month November Day 23 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1907
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Bohatka	
14. MOTHER'S MAIDEN NAME Sophe Smeya		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ----	
16. SOCIAL SECURITY NO. 235-22-4238		17. INFORMANT Gloria J. Shinn -66 Salamaue Ct. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of left breast. (c) Carcinoma of left breast.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9.22 , 19 58 , to 11.23 , 19 58 , that I last saw the deceased alive on 11.23.58 , 19 58 , and that death occurred at 1.30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Samadi		ADDRESS (Street, city or town, state) Hollywood Maryland	
PHYSICIAN'S NAME (Type) ABDUSSAMED SAMADI M.D.		DATE SIGNED 11/23/58	
22a. BURIAL CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 11/23/58	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Bellaire, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Lepnardtown, Md.		24a. REC'D BY REGISTRAR DATE DEC 1 '58	24b. REGISTRAR'S SIGNATURE Carlton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Residence		Birth Date		Birth Place	
Signature of Registrar		Signature of Physician		Signature of Coroner	
Date of Registration		Time of Registration		Place of Registration	

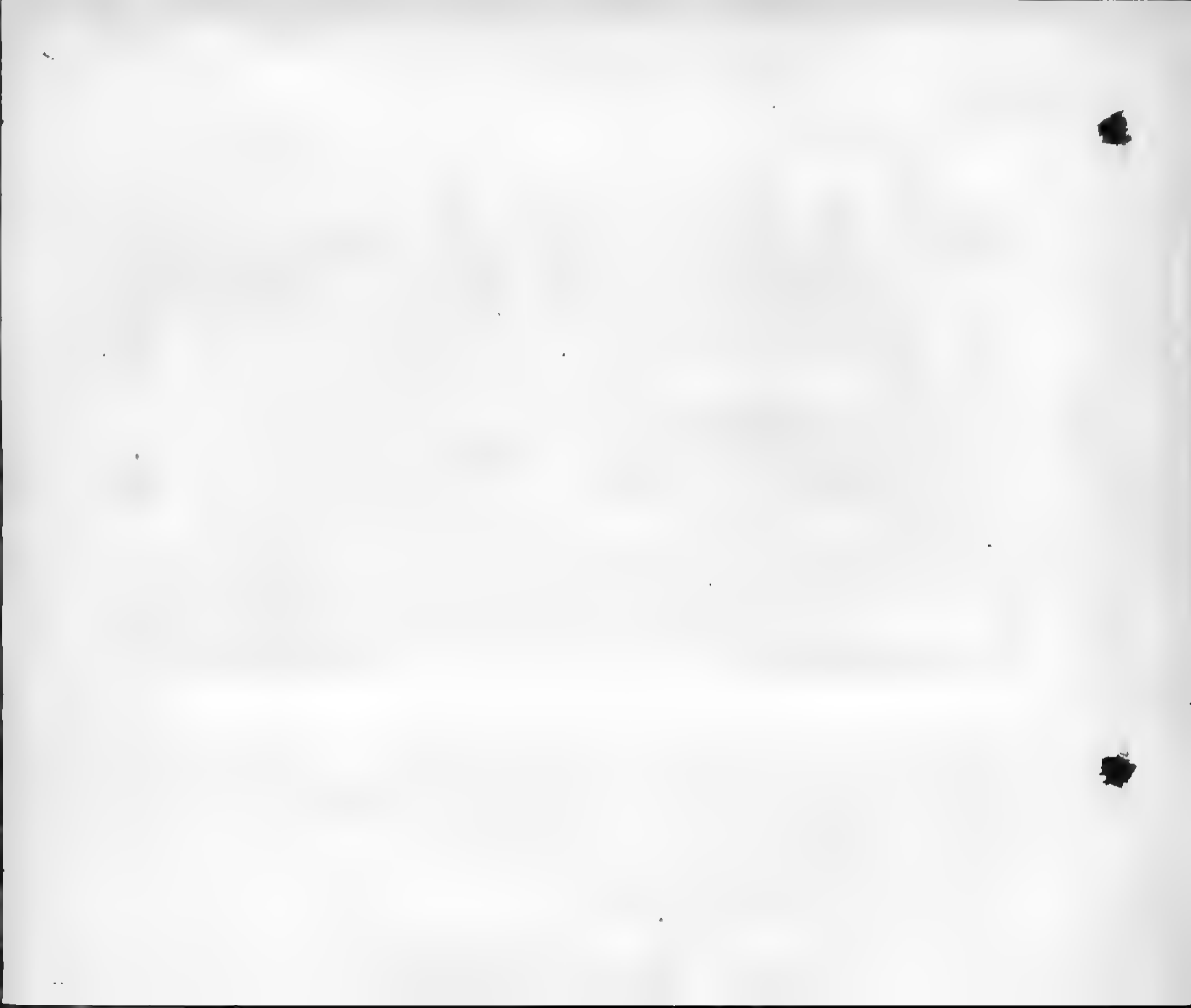
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12913
CERTIFICATE OF DEATH

12913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Warren Last Clarke				4. DATE OF DEATH Month Nov. Day 30 , Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1868	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tidewater fisheries				10b. KIND OF BUSINESS OR INDUSTRY State of Md.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Worthington Clarke				14. MOTHER'S MAIDEN NAME Ann Milburn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. No.			
17. INFORMANT Virginia A. Clarke				Address Ridgem Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 446X DUE TO Chronic nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized arterio sclerosis DUE TO (c) 10 years INTERVAL BETWEEN ONSET AND DEATH 3 days 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov 29, 1958 to Nov 30, 1958 , that I last saw the deceased alive on Nov 29, 1958 , and that death occurred at 10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Maryland DATE SIGNED Dec 11/58							
ACTUAL SIGNATURE P. J. Bean				PHYSICIAN'S NAME (Type) P. J. Bean M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/4/58		22c. NAME OF CEMETERY OR CREMATORY St. Michael's	
22d. LOCATION (City, town, or county) Ridge, Maryland				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		24a. REC'D BY REGISTRAR DEC 3 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

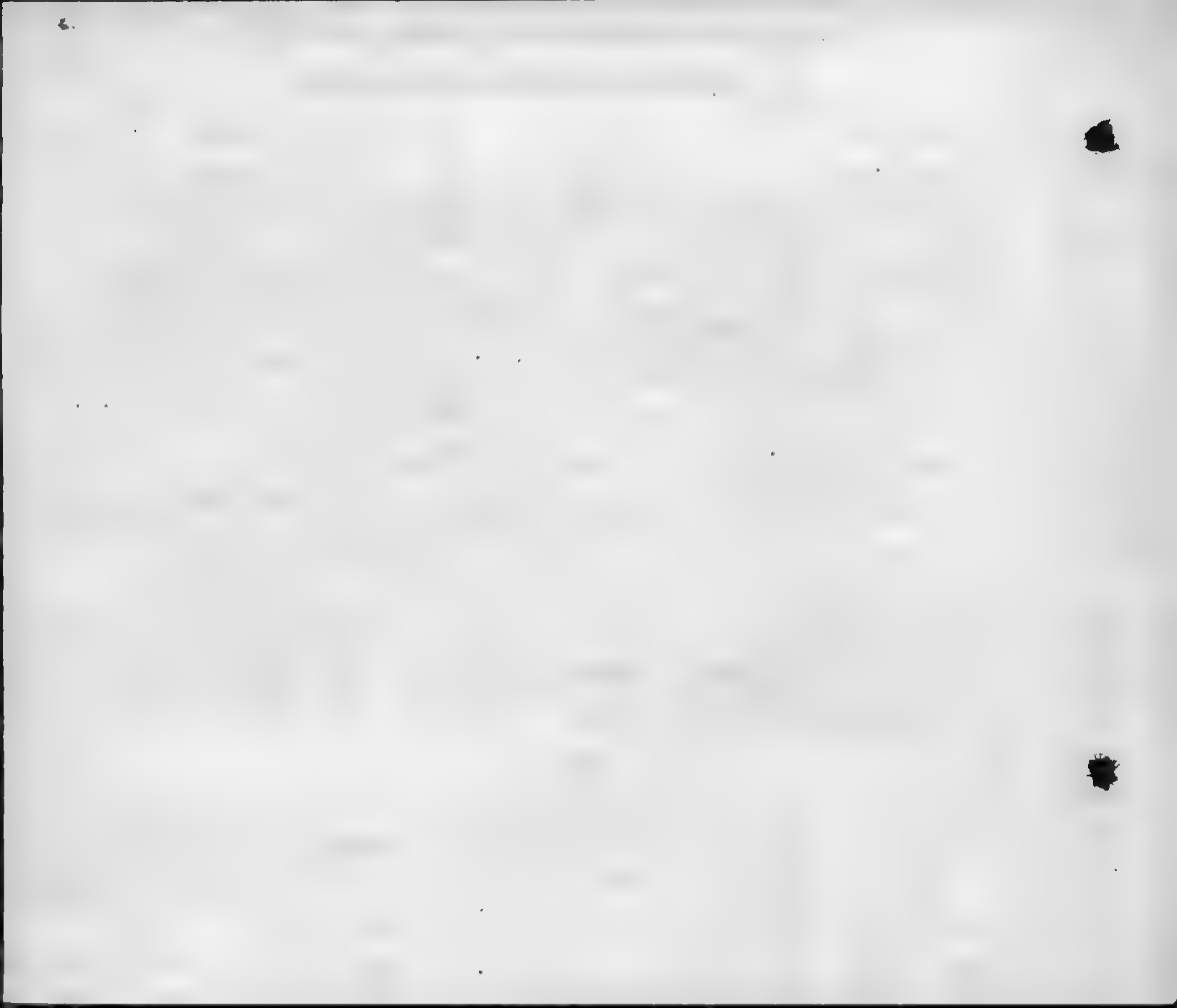
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12914

12914 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Mary's</u>		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hollywood</u>		LENGTH OF STAY (In this place) <u></u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hollywood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u></u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (Type or Print) <u>James Thomas Greenwell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 27, 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May, 7, 1892</u>	
9. AGE last birthday <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James T. Greenwell</u>				14. MOTHER'S MAIDEN NAME <u>Laura Mae Redman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-16-4665</u>		17. INFORMANT & ADDRESS <u>Phoebe E. Greenwell Hollywood, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4d.d. IMMEDIATE CAUSE (A) <u>Myocarditis Chronic failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>Oct 25, 1958</u> , to <u>Nov 25, 1958</u> , that I last saw the deceased <u>alive on</u> <u>Nov 25, 1958</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Charles E. Greenwell</u> M.D. <u>Leonardtown, Md.</u> DATE SIGNED <u>Nov 27, 1958</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/29/1958</u>		NAME OF CEMETERY OR CREMATORY <u>Saint John's</u>		LOCATION (City, town, or county) (State) <u>Hollywood, Maryland</u>	
24. REC'D BY REGISTRAR <u></u>		REGISTRAR'S SIGNATURE <u>Wm. S. Clark</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattinzley, Leonardtown, Md.</u>			
DATE <u>DEC 2 '58</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12915	
12915										12915	
CERTIFICATE OF DEATH										Reg. Dist. No.	
1 PLACE OF DEATH a. COUNTY St. Mary's MARYLAND					2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maddox					c. LENGTH OF STAY IN 1b life					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Maddox.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS /					e. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Frederick Cleveland Higgs					4. DATE OF DEATH Month Day Year Nov. 30, 19 58						
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1958		9 AGE (In years last birthday) 5 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min 5 24	
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) 33333					10b. KIND OF BUSINESS OR INDUSTRY ###		11. BIRTHPLACE (State or foreign country) Maryland/ Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph Higgs					14. MOTHER'S MAIDEN NAME Rae Higgs Boswell						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Higgs Address Maddox, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hydrocephalus 344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE David L. Mosman M.D. ADDRESS (Street, city or town, state) Mechanicville, Md. DATE SIGNED PHYSICIAN'S NAME (Type) _____											
22a. BURIAL, CREMATION, REMOVA. (Specify) Burial		22b. DATE THEREOF 12/1/58		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart			22d. LOCATION (City, town, or county) (State) Bushwood, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.						24a. REC'D BY REGISTRAR DATE DEC 3 '58		24b. REGISTRAR'S SIGNATURE W. S. S. S.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12916

CERTIFICATE OF DEATH

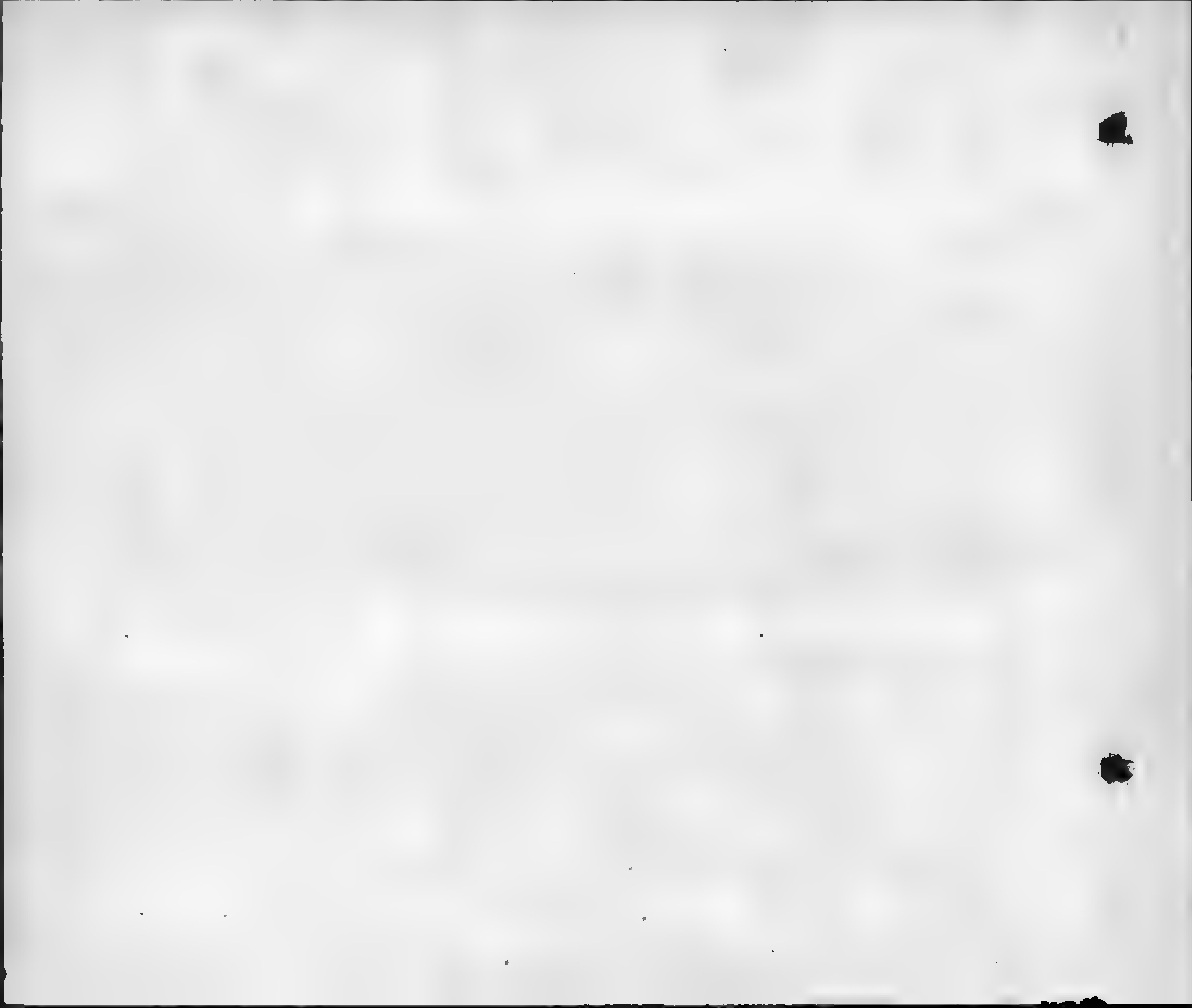
12916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's</u>				d. STREET ADDRESS <u>#266A Route 5</u>			
3. NAME OF DECEASED (Type or print) First <u>Hilda Louise</u> Middle <u>Meredith</u> Last <u>Meredith</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-58</u>	9. AGE (In years last birthday) yrs. <u>38</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>11</u> Hours <u>38</u> Min <u>38</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Raymond Meredith</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>760.0</u>			
17. INFORMANT <u>Hopital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UNDETERMINED CAUSE - POSSIBLE</u> DUE TO <u>760.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTRACRANIAL HEMORRHAGE</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BREACH PRESENTATION; ASPHYXIA; RESPIRATIONS NOT ESTABLISHED</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>6:00 PM 11/29, 1958</u> to <u>6:10 11/29, 1958</u> that I last saw the deceased alive on <u>11/29, 1958</u> and that death occurred at <u>6:10 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state)			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>J. Roy Guyther M.D.</u>				<u>Mechanicville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		22d. LOCATION (City, town, or county) (State) <u>Leonardtown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>				ADDRESS <u>Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR <u>DEL 2 58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



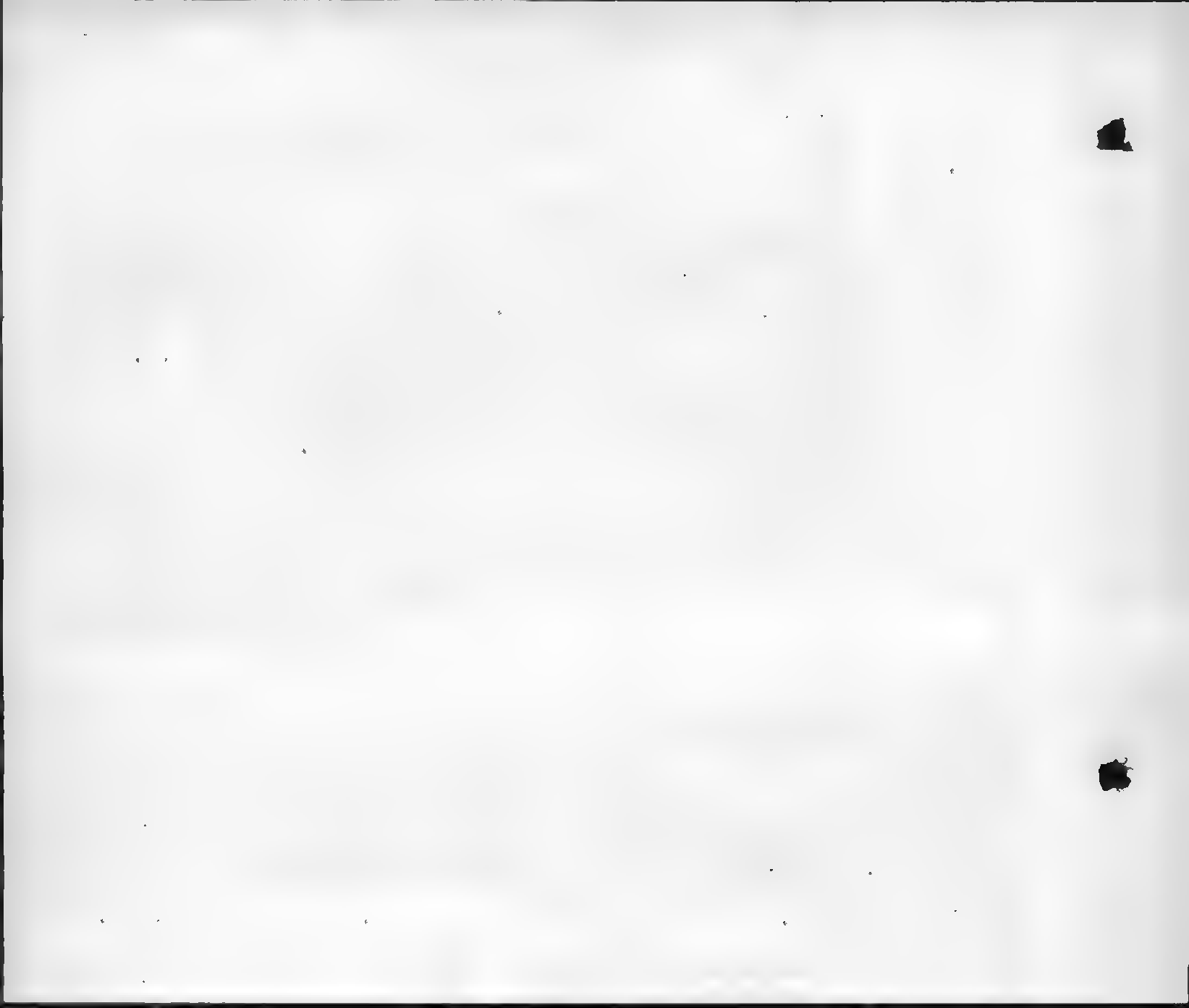
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12917

12917 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island	
		f. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) William Harry Robrecht		4. DATE OF DEATH November 21 , 19 58	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1877
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Robrecht		14. MOTHER'S MAIDEN NAME Anna Twilley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Lelia M. Robrecht		Address St. George Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) hemera DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Ascending urinary tract infection DUE TO (c) 2 months INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arterio-sclerosis and chronic arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November , 19 50 , to Nov 21 , 19 58 , that I last saw the deceased alive on Nov 17 , 19 58 , and that death occurred at 12:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Nov 21/58			
ACTUAL SIGNATURE A. J. Bean M.D.			
PHYSICIAN'S NAME (Type) P. J. Bean M. D. Great Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/58	22c. NAME OF CEMETERY OR CREMATORY St. Francis	22d. LOCATION (City, town, or county) (State) St. George Island, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR NOV 25 '58	
ADDRESS Leonardtwn, Md.		24b. REGISTRAR'S SIGNATURE W. S. Evans	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

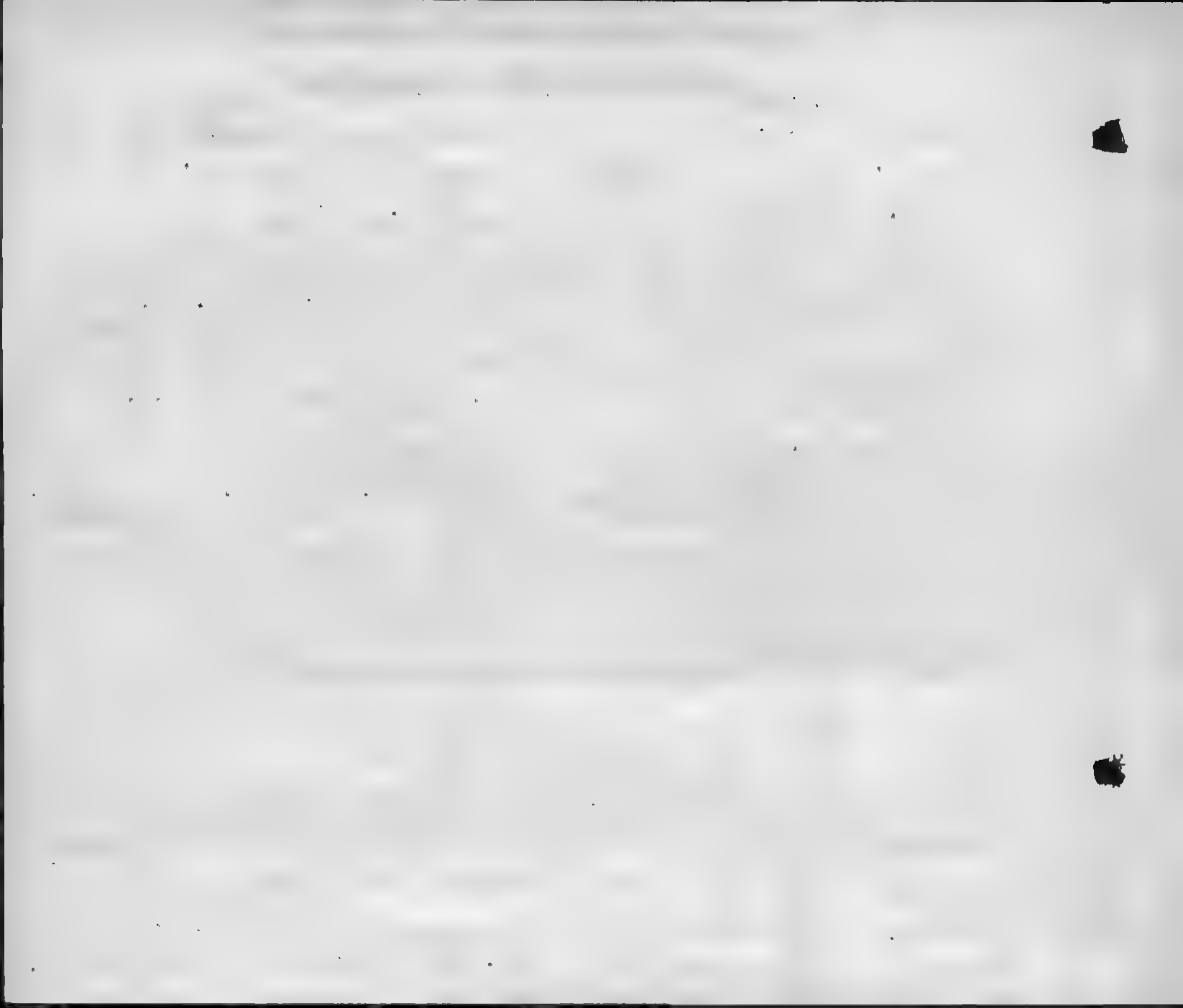
12918

12918

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		STATE MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN St. George Island		LENGTH OF STAY (In this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN St. George Island			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Gabriel (Middle) Edward (Last) Thomas				(Month) Nov. (Day) 28, (Year) 19 58			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 27, 1876	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months 8 Days 1	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. George Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Thomas				14. MOTHER'S MAIDEN NAME Margaret			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Myrtle P. Thomas St. George Island,			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) coronary occlusion						5 days	
ANTECEDENT CAUSE(S) DUE TO (B) coronary sclerosis						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Generalized arteriosclerosis						16 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 25, 1958 to Nov. 28, 1958 that I last saw the deceased alive on Nov. 27, 1958 and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
SIGNATURE D. J. Hen M.D.				ADDRESS (Street, city, town, state) Grant Hill		DATE SIGNED Nov 29/58	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/1/58		NAME OF CEMETERY OR CREMATORY Cedar Hill		LOCATION (City, town, or county) (State) 4000 Suitland Road Washington, D.C.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE DEC 3 '58		C. J. Hen		W. Clarke Mattingley		Leonardtwn, Md.	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 11 Film G236 12-3-58 et

12919

CERTIFICATE OF DEATH

Item 1 Film G236 12-4-58 et

12919

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Leonardtwn</u>		LENGTH OF STAY (In this place) <u>14 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Park Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Mary's Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print) <u>James Robert Vincent</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 23, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 2, 1886</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-1978</u>		17. INFORMANT & ADDRESS <u>Bernice V. UHhle Park Hall, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Broncho-pneumonia</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary sclerosis</u>						<u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-11-58</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M. 5-11-58</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 5, 1958</u>, to <u>Nov. 23, 1958</u>, that I last saw the deceased alive on <u>Nov. 23, 1958</u>, and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>Great Mills Md</u>		DATE SIGNED <u>Nov 24/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/26/58</u>		NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		LOCATION (City, town, or county) (State) <u>Great Mills, Md.</u>	
24. REC'D BY REGISTRAR <u>NOV 26 58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>			
DATE		ADDRESS <u>Leonardtwn, Md.</u>					

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of coroner		12. Signature of jury	
13. Signature of witness		14. Signature of witness		15. Signature of witness	
16. Signature of witness		17. Signature of witness		18. Signature of witness	
19. Signature of witness		20. Signature of witness		21. Signature of witness	
22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness	
28. Signature of witness		29. Signature of witness		30. Signature of witness	
31. Signature of witness		32. Signature of witness		33. Signature of witness	
34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness	
40. Signature of witness		41. Signature of witness		42. Signature of witness	
43. Signature of witness		44. Signature of witness		45. Signature of witness	
46. Signature of witness		47. Signature of witness		48. Signature of witness	
49. Signature of witness		50. Signature of witness		51. Signature of witness	
52. Signature of witness		53. Signature of witness		54. Signature of witness	
55. Signature of witness		56. Signature of witness		57. Signature of witness	
58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness	
64. Signature of witness		65. Signature of witness		66. Signature of witness	
67. Signature of witness		68. Signature of witness		69. Signature of witness	
70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness	
76. Signature of witness		77. Signature of witness		78. Signature of witness	
79. Signature of witness		80. Signature of witness		81. Signature of witness	
82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness	
88. Signature of witness		89. Signature of witness		90. Signature of witness	
91. Signature of witness		92. Signature of witness		93. Signature of witness	
94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness	
100. Signature of witness		101. Signature of witness		102. Signature of witness	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12920

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 54 Chinlee Drive		d. STREET ADDRESS 54 Chinlee Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Marie Wingo		4. DATE OF DEATH Month Day Year 11, 20, 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 June 1958
9. AGE (In years last birthday) yrs. 5 Months 2 Days 2		10. IF UNDER 1 YEAR IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph F. Wingo		14. MOTHER'S MAIDEN NAME Eunice E. Sunila	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT J.F. Wingo - 54 Chinlee Dr.		Address Lexington Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) 491X (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Undetermined			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Wm. D. Boyd, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 11/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/21/58	
22c. NAME OF CEMETERY OR CREMATORY Daggett, Michigan		22d. LOCATION (City, town, or county) (State) Daggett, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

9VVVVVVVVVV

STATE OF
NEW YORK

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1920

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Manner of Death	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Place of Issue		Official Seal	